The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. For more information about your coverage, or to get a copy of the complete terms of coverage, look in the terms in the policy or plan document on Inside Guardian or Guardian Online, or by calling MyHR at 1-877-870-6947. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary on Inside Guardian or Guardian Online, or by calling MyHR at 1-877-870-6947 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In Network: $1,500 Individual / $3,000 Family Out of Network: $3,000 Individual / $6,000 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific service, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network providers.: $4,000 Individual/ $8,000 Family For out-of-network providers: $8,000 Individual/ $16,000 Family	The out–of–pocket limit is the most you could pay during a calendar year for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums**, balanced-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit
Will you pay less if you use a network provider?	Yes. See www.aetna.com or call 1-866-244-1573 for a list of network providers.	If you use a network doctor or other health care provider, this plan will pay some or all the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, network providers, or participating for providers in their network
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.

Questions: Call **1-866-244-1573** or visit **Inside Guardian or Guardian Online**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call the number above to request a copy.

- All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance after deductible	30% coinsurance after deductible	None
	Specialist visit	10% coinsurance after deductible	30% coinsurance after deductible	None
If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No Charge	30% coinsurance after deductible	None
	Primary care visit to treat an injury or illness	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	Prior Authorization required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**.	Generic	**Non-Preventive** **Retail up to a 30-day supply:** 0% coinsurance until deductible met, then $10 copay **Mail Order up to a 90-day supply:** 0% coinsurance until deductible met, then $25 copay **Preventive** **Retail up to a 30-day supply:** $10 copay **Mail Order up to a 90-day supply:** $25 copay	Not Covered	Deductible does not apply to preventive retail and/or mail order drugs
	Preferred Brand Name	**Non-Preventive** **Retail up to a 30-day supply:** 0% coinsurance until deductible met, then 25% coinsurance with a $35 min./ $75 max. copay. **Mail Order up to a 90-day supply:** 0% coinsurance until deductible met, then 25% coinsurance with a $87.50 min. / $187.50 max. copay **Preventive** **Retail up to a 30-day supply:** 25% coinsurance with a $35 min./ $75 max. copay, **Mail Order up to a 90-day supply:** 25% coinsurance with an $87.50 min./ $187.50 max. copay	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Non-Preferred Brand Name	**Non-Preventive** **Retail up to a 30-day supply:** 0% coinsurance until deductible met, then 35% coinsurance with a $60 min. / $150 max. copay. **Mail Order up to a 90-day supply:** 0% coinsurance until deductible met, then 35% coinsurance with a $150 min./ $375 max. copay. **Preventive** **Retail up to a 30-day supply:** 35% coinsurance with a $60 min./$150 max. copay **Mail Order up to a 90-day supply:** 35% coinsurance with a $150 min./ $375 max. copay	Not Covered	Deductible does not apply to preventive retail and/or mail order drugs
	Specialty drugs	Covered; copays/ coinsurance for non-preventive medications apply	Not Covered	Specialty medications must be filled through the Express Scripts specialty pharmacy, Accredo. Prior Authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance after deductible	None
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	10% coinsurance after in-network deductible	None
	Emergency medical transportation	10% coinsurance after deductible	30% coinsurance after deductible	
	Urgent care	10% coinsurance after deductible	30% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible	
	Mental/Behavioral health outpatient services	10% coinsurance after deductible	30% coinsurance after deductible	None

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
	Substance use disorder outpatient services	10% coinsurance after deductible	30% coinsurance after deductible	None
	Substance use disorder inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If you are pregnant	Office visits	10% coinsurance after deductible	30% coinsurance after deductible	None
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	Routine Pre-Natal is covered at no charge
	Childbirth/delivery facility services	10% coinsurance after deductible	30% coinsurance after deductible	Stays exceeding delivery timeframes Prior Authorization is required. Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty. 100 visits per calendar year combined In and Out-of-Network.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty. 30 visits combined per calendar year. Physical and Occupational Therapy; 30 visits per calendar year combined for Speech and Post-Cochlear Therapy.
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	No limitation on visits
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty. 90 days per calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Durable medical equipment	10% coinsurance after deductible	Not Covered	None
	Hospice services	10% coinsurance after deductible	30% coinsurance after deductible	Out of Network Prior Authorization required or benefits will be reduced by a $500 penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses			
	Children's dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Adult routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Long-term care
- Dental Care (Adult)
- Weight loss programs
- Non-emergency care when traveling outside the U.S

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture covered with limitations
- Bariatric Surgery covered with limitations
- Hearing aids covered with limitations
- Infertility Services covered with limitations (dependent children are eligible for services when deemed medically necessary)
- Private-duty nursing covered with limitations
- Routine foot care covered with limitations

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-866-451-3399. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact us at 1-866-244-1573 or visit www.aetna.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-866-244-1573.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-244-1573.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-244-1573.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-244-1573.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,290
- **Patient pays:** $2,250

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance	$580
Limits or exclusions	$170
Total	**$2,250**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays**:$50
- **Patient pays:** $5,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,150
Copays	$0
Coinsurance	$0
Limits or exclusions	$4,200
Total	**$5,350**